BUILDING SCHOOL READINESS THROUGH HOME VISITATION

Appendix E.
Frequently Asked Questions

Prepared for the First 5 California Children and Families Commission
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January 29, 2003

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The "Building School Readiness Through Home Visitation" report and appendices are a statewide project funded by the First 5 California Children and Families Commission.

APPENDIX E.
FREQUENTLY ASKED QUESTIONS ABOUT HOME VISITING

The following are some commonly asked questions about home visiting services:

The answers to these questions, which distill the lessons learned from the most important research findings, appear below:

1. Should We Launch a Home Visiting Program to Promote School Readiness?

The answer depends upon the goals for the program and the community.

Goals. If the proposed goals are primarily to promote cognitive child development, then center-based early childhood education programs provide larger and more consistent benefits than do home visiting programs. If the proposed goals are to promote parenting skills and prevent child abuse, then home visiting programs may be helpful, especially if complemented by parent groups.

Why? Because home visiting programs are primarily parent-focused programs. Services are directed at the parent and seek to change the parent's behavior (e.g., parent education about child development, encouraging parents to go back to school, helping parents find stable housing). Even programs that have explicit goals to promote child development usually rely on parents' changing their behavior (e.g., reading to their children every day, talking with their children in ways that promote their development, working through prescribed "homework" activities with their children) as the means of promoting child development. So, child development gains cannot be seen unless parents change their behavior, and, even if parents do change, it may take some time before changes will be seen in children.

Furthermore, families typically receive no more than 40 hours or so of home visiting services a year, and sometimes much fewer than that. That is not a lot of time in which to persuade parents to change a complex set of behaviors related to parenting, especially if

parents have not specifically sought out information about parenting and do not believe they need to change.

In contrast, center-based early childhood education programs such as preschool offer services, focused directly on children, for 20 to 40 hours per child over the course of a single week. That provides much more attention directly on child development, and directly on the child, not mediated by parents.

Therefore, as might be expected, research indicates that (1) home visiting programs more often produce benefits in outcomes related to parenting than in outcomes related to child development, and (2) center-based early childhood education programs produce gains in children's cognitive development as much as four or five times greater than those produced by home visiting programs.

That said, there is also evidence that parent support groups produce equivalent and perhaps larger benefits for parents than do home visits. But, the parents who enjoy home visits are not necessarily the same who attend group meetings, and vice versa. Therefore, communities that offer parents multiple service strategies may show the largest eventual benefit.

If the proposed goals relate to child health, then it is probably more important to make sure that children are insured and have access to health services than to launch a new home visiting program. Home visiting programs do not consistently promote better or more appropriate use of preventive health services, perhaps because the effects of health insurance and the availability of convenient health services (both of which are largely driven by federal, state, and local policy decisions) are so much larger than the effects that can be generated by advice that home visitors give families about the importance of preventive health care. In other words, even if parents are persuaded by their home visitor to take their children for a well-baby check-up or to be immunized, but their children are not eligible for insurance or health services are several bus rides away, then their use of preventive health care services is unlikely to change.

Community. In some places such as small, rural communities, center-based early childhood education programs are not feasible. There are too few children to make a center economically feasible, or families live so far apart from one another that they would be unwilling to travel to a center.

In other, perhaps most, communities, families may be unwilling to place their very young infants and toddlers in a center-based early childhood education program. And, the quality of much infant and toddler child care is such that it may not benefit children very much anyway.

Finally, if the goal is to reach families who are extremely isolated socially, then home visiting may be a way to reach them before children enter school.

In these communities and for these families, a home-based program can be one of the only ways to even have a chance of bringing school readiness-related services to families.

2. What Home Visiting Model Should Be Selected?

Abt Associates has reviewed the family support literature from 1965 through 2000 and concludes, "There is no single effective program model…. there is no single program approach, curriculum or service strategy that has demonstrated effectiveness across a range of populations." Models that have been tested in different communities and with different populations usually show a range of effects, and even models such as the Nurse-Family Partnership, which arguably has shown the most positive effects in rigorous randomized trials, do not always generate the same magnitude effects across all population groups or across all measures.

Therefore, the best way to select a home visiting program is to choose a model that has demonstrated benefits on goals that you are interested in addressing, with families similar to the families that you are trying to serve, and living in communities similar to yours.

For example, some programs focus primarily on low-income women who are pregnant with their first child, while others seek to reach all families with children under age 3 in a community. Some programs focus primarily on preventing child maltreatment, others on child development, and still others on moving families from welfare to work.

These are very different programs, with very different goals. Do not expect that one program will generate the same effects as another, just because they both rely on home visiting as a primary service strategy.

Programs may state that they address all these goals, and perhaps others as well. But, consider what the program is at its essence, because, if home visitors are only able to complete about half the visits they have planned (which is about typical), they may only be able to deliver the high notes of the program's curriculum. What does the curriculum content suggest will be the primary area of program focus in an abbreviated program? It may be that only some of the program goals will be able to be addressed.

In addition, consider the extent to which programs depend upon other services for their success. If, for example, home visits focus on parents' self-sufficiency and rely on center-based early childhood education to promote child development, then communities must have high quality child care, or the whole package of services will not lead to benefits in child development.

3. Does Who Administers the Program Make a Difference?

Yes. Different agencies that administer the same model can create programs that differ in how they operate, in how families perceive them, in the outcomes they produce, and in the complementary services that families receive.

For example, evaluators of Hawaii's Healthy Start program (the forerunner of the Healthy Families America program) discovered the families left the program at its different sites at differing rates, ranging from 38-64% over the first year. The different attrition rates were attributable to different philosophies held by the three administering agencies regarding how hard to try to hold onto families. In the agency with the highest attrition rate, the staff believed that it was more important to serve families that really wanted to participate than to try to hold onto more reluctant participants. In the agency with the lowest attrition, the staff believed that it was precisely the hard-to-reach families that needed help the most, and they worked very hard to retain those families. Clearly, parents would experience the program differently at each site.

Similarly, staff training and background leads to differences in what families hear from their home visitors. The test of the Nurse-Family Partnership in Denver, for example, suggested that paraprofessional home visitors spent more time during their home visits talking with families about pregnancy planning, education, work, and family material needs, while nurses spent a greater portion of their home-visit time on physical health during pregnancy and on parenting after delivery. Home visitors with training in child development might spend more time talking about those issues. Again, families might experience the same program differently, depending upon who their home visitor is – and those hiring decisions are often related to which agencies are operating the programs.

Some suggest that families may also perceive programs differently, depending upon the administering agency. For example, families may view programs operated out of a county social service agency suspiciously because they may fear home visitors are scrutinizing them for evidence of child maltreatment. Among community-based organizations, an agency with a long history and good reputation in the community may be more likely to enroll and retain families.

Programs administered by school districts, as many Home Instruction for Parents of Preschool Youngsters (HIPPY) and Parents as Teachers (PAT) programs are, may also produce different benefits, such as greater parent involvement in their children's education in later years or greater support for school district bonds in elections. In other words, such programs may break down barriers that parents may feel toward schools and instead encourage them to become supporters of education and the schools.

Finally, programs that are operated out of multi-service agencies may be more likely to refer families to complementary services, and the families may be more likely to receive them. For example, a study of Parents as Teachers in three inner-city communities suggested that the home visiting program that was co-located with other services might have been the most effective of the sites.

This is the promise offered by co-locating home visiting programs with family resource centers or on school-sites, and states such as Connecticut have spent millions to co-locate home visiting programs such as Parents as Teachers in school-based family resource centers, but there is no research yet on the comparative advantage of these arrangements.

4. Should Programs Focus on Just a Few Goals or Should They Be Broad and Comprehensive?

The National Academy of Sciences concludes, "Widely implemented programs that have extended their services beyond home visiting to provide a mix of adult education, job training, parenting education, and child care have also yielded, at best, modest results, particularly when they do little to address the multiple risk factors that often characterize the families they are trying to reach and do not focus extensive resources on addressing the parent-child relationship."

Again, the explanation may lie partially in the number of hours that are spent with families. It is probably not possible for programs to address family economic needs, parenting, child development, as well as other issues in the two or three hours each month that home visitors spend with each family.

Even if it were, it is unlikely that a single home visitor will be equally skilled in addressing all these issues. Some programs have responded to this by creating a team approach, with different staff members assigned different responsibilities. In Early Head Start, for example, home visitors were not always able to address their child development focus, because parents wanted to talk about broader family needs. Some programs spent as little as 20% of their time on child development, although others spent more. Some Early Head Start sites have responded by having home visitors focus on child development and other staff -- resource specialists -- focus on family needs. Child involvement was reported highest in programs that provided family development services in separate home visits and in programs that planned activities using the Parents as Teachers curriculum (which the evaluators report facilitates direct involvement with the child). The Cal-SAHF approach, which employed multidisciplinary teams, exemplified this approach.

Whether the program's stated goals are focused or comprehensive, however, may not matter as much as how home visitors translate those goals into action. Programs produce benefits in those outcomes on which home visitors focus. For example, an evaluation of a Healthy Families America program in San Diego revealed that health-related outcomes improved after mid-course training for home visitors led them to emphasize health issues during their visits.

5. When Should Services Begin? How Long Should They Last? How Intensive Should They Be?

Onset: Prenatal enrollment affords some advantages in programs that seek to begin services around the time of birth. Pregnant women may be especially receptive to intervention as it is a natural time to have questions and concerns about their own health as well as the health and development of their babies. If services begin before birth, then it is possible that the rapport between home visitor and parent will be stronger – and perhaps will last longer. Interim results from Early Head Start suggest that prenatal enrollment is associated with larger benefits for more outcomes, and the Nurse-Family Partnership, which has produced some of the largest benefits for families, begins prenatally.

Duration and Intensity: Generally, in early childhood programs, more intensive and longer-lasting services produce larger benefits for children. Some home visiting programs have responded by trying to extend home visiting services for the first five years of a child's life (e.g., Parents as Teachers). However, only a minority of families typically remain enrolled for that length of time. In fact, in most programs, 30-40% of families have left the program by the end of two years, and 50-70% may have left by three years. In addition, most families typically receive fewer home visits, often only half as many, as they are scheduled to receive. Programs that schedule weekly visits often can only complete a little over two visits per month.

Researchers do not know what the minimum number or intensity of visits is needed before results can be generated, but these practical truths about the delivery of home visits suggest that programs might more profitably attempt a relatively intensive intervention during the early months of a family's involvement than to try to hold onto families for many years.

In other words, rather than monthly home visits for 3 years, it might be better to try for weekly home visits for six months, then fading to twice per month for 2 years. Even if these levels of service are not achieved, and they probably will not be, programs should be staffed to permit them because that will allow the possibility of increasing service levels if a family enters a crisis and needs some extra time and attention.

6. Whom Should We Hire as Home Visitors?

Home visitors are the central figures in any home visiting program. They recruit families, deliver the curriculum, link families with other services, and encourage and support them in their efforts to change. The success of the program rides on the shoulders of home visitors, and there is no decision so important as the hiring decision about a home visitor.

Hiring decisions should be driven by program goals, design, and home visiting model. For example, the Nurse Family Partnership model specifies that the home visitors must

be nurses. The HIPPY and Parent-Child Home Program specify that home visitors be drawn from the same population as are participating families.

But, in many other program models, the decision is left up to the individual program sites. Benefits have been found in home visiting programs that use visitors with many different backgrounds, including those that use paraprofessionals. And, most experts agree that the most important skills for a home visitor are not necessarily skills that are derived from an educational degree. For example, a description of the skills needed in a home visitor in the Teenage Parent Home Visitor demonstration program included the following: "A thorough understanding and support of the purposes of the intervention; an ability to plan and execute visits that successfully build on clients' behaviors; sound judgment and maturity; good listening and observing skills; an ability to communicate effectively by asking appropriate questions and accurately interpreting responses; knowledge of how to assess risks; knowledge of local resources; and the ability to effectively interact with other professional service providers."

However, more and more programs are turning toward using individuals with more training and educational experience. Healthy Families America, for example, began as a paraprofessional home visiting program, but now, over 80% of the home visitors in its program sites are individuals with college attendance or degrees, typically in child development, social work, nursing, or education.

Paraprofessionals are usually advocated for three primary reasons: (1) they are thought to have a better understanding of the families that are being served, and so will be better able to engage families and will therefore produce greater benefits; (2) they earn less than professionals, and so program costs can be kept lean; and (3) the advancement of paraprofessionals is sometimes a specific program goal.

But, research and practical experience suggest that paraprofessionals can present some extra challenges too. Because paraprofessionals are usually paid modest wages, they may be more likely than higher-paid workers to leave programs for jobs that pay more. Some research indicates that the turnover rate among paraprofessionals may be especially high. That results in increased costs for programs as they must hire and retrain new workers at a faster rate. In home visiting programs, where the success of the intervention hinges upon the ability of home visitors to form rapport with families, turnover can be very damaging. In addition, because this may be the first job for many paraprofessional home visitors, they may need extra supervision and assistance to master basic job skills.

For many programs, therefore, the true cost of employing paraprofessionals winds up being about as high as employing professionals. That means that the main reasons to hire paraprofessionals should be because they are better at engaging and serving families, and/or because hiring paraprofessionals is part of the mission of the program (e.g., HIPPY or PCHP).

The nature of the home visiting program plays a part in this, too. Some programs such as HIPPY and the Parent-Child Home Program have fairly well-specified curricula and

more routinized lesson plans. Others rely to a far greater extent upon the experience and skills of the home visitor to work with families to develop individualized services that span a wide range of goals. For those far-reaching programs, it may be best to rely upon workers who have more training, background, and experience, than to rely upon relative newcomers to the field. For example, evidence from an evaluation of the broad-ranging Nurse-Family Partnership suggests that, for that program model, paraprofessionals produced benefits for families that were about half as large as the benefits produced by nurses.

7. Should We Target Services to Particular Groups or Offer Them Universally?

This is an important issue because if the groups that benefit most could be predicted, then services could be more efficiently and effectively delivered.

Some home visiting programs are offered universally, that is, to every mother with a child in a certain age range, who lives in a particular geographic area. Other programs specifically focus on particular groups where eligibility is fairly broad and based on easily observable characteristics (e.g., low-income women pregnant with their first baby). Still other programs use screening questionnaires that combine demographics with scores on tests of mental health status or stress levels to identify mothers who are at higher-than-average risk for poor outcomes of one sort or another, such as child abuse and neglect. In practice, however, funding is rarely sufficient to cover all eligible families, and even universally available programs often prioritize services to those families judged to be at higher risk or more in need.

Many programs are better able to retain some subgroups of families, and some families benefit more than others from a given home visiting program. But, there is little consistency across program models and program sites in who those families are. For example, the Nurse-Family Partnership targets services to low-income, unmarried women because research results indicate that such women benefit most, and that the program only pays off economically when delivered to that group. The program also appears to generate extra benefits for those women who possess low psychological resources (low IQ, poor coping skills, and poor mental health) upon enrollment. Evaluations of other home visiting programs identified other groups as benefiting most or engaging more fully in program services: Spanish-speaking children of Latina mothers in one PAT site; higher educated and higher income mothers in one evaluation of HIPPY; African-American and first-born children in the early years of an evaluation of Early Head Start.

Several researchers have suggested that the most at-risk families, defined in a variety of ways, may benefit most. If so, this might be because home visiting services help place a supportive floor underneath the neediest families, or because those families feel the strongest need and motivation to change. For example, researchers have suggested that home visiting programs that target children with special biological or developmental needs have especially strong effects on children's cognitive and social-emotional

outcomes, perhaps because parents are especially determined to help these children with clear and obvious needs for special assistance.

Or, perhaps the effects of home visiting programs can be observed most easily among the group that is the neediest because that group has the most room for improvement. In other words, one can only create large change in a group that possesses high rates of the behavior to be changed.

Or, perhaps, home visitors recognize the neediest families in their caseloads and find a way to offer them more intensive services. For example, families who had low psychological resources at baseline in the Elmira site of the Nurse Family Partnership were the families who benefited most from the program, but they were also the families who received the most visits and contacts from home visitors.

Although it is probable that some families will prefer and benefit from one model of home visiting services over another, little research has been conducted to clarify which families will benefit most from any single home visiting model. Research does, however, clearly suggest that in-depth home visiting programs will not produce benefits across the whole population of families with young children. Intensive, universal home visiting will not lead to broad benefits. The benefits of a single initial home visit to all families, or to a broad range of families, have not been evaluated, although experience in some communities (e.g., Cuyahoga County, Ohio – See Appendix D), suggests that such home visiting programs are extremely popular.

For programs that employ a screening instrument, there are some additional cautions. Most programs that use screening instruments use them as a way to identify families at high-risk for child abuse and neglect, but most panels and research reviews have specifically recommended against the use of screening instruments for that purpose. Screening instruments may be accurate for a brief time, but family circumstances can change, and the screen could easily miss families whose risk profile changes over the course of a few years. And, if screens identify too many families who are not really at-risk, families may experience unwarranted stigmatization.

Even if screening instruments are accurate, programs must make sure that program services address the risk factors identified through the screening instrument. For example, results of the Nurse Family Partnership (which does not use a screening instrument) indicated that it did not prevent child abuse among families with high rates of domestic violence, resulting in a revision of the NFP curriculum. But, domestic violence might be one of the very risk factors that would screen a family into another home visiting program, and that program too might not have the services in place to help the family. Research suggests that home visitors often feel awkward or uncomfortable addressing several family issues that are often embedded in screens: domestic violence, mothers with mental illness, especially depression, and substance abusing families. If programs do not have curricula concerning those problems, or if home visitors are not at ease in dealing with them, then program goals are unlikely to be achieved, and the initial screens will not have accomplished their purposes.

8. How Much Does Home Visiting Cost, and How Can We Pay For Services?

Generally, the cost of home visiting programs ranges from $1,300 to $5,000 per family per year, largely depending upon personnel costs, but very comprehensive programs such as Early Head Start, might cost as much as $11,500 per family per year. A recent review summarizes annual program costs per family for several of the large home visiting models as follows (all in 1998 dollars):

$1,341 for HIPPY
$2,118 for PAT
$2,203 for Healthy Families America
$2,995 for Hawaii's Healthy Start
$2,842-$3,249 for the Nurse-Family Partnership (costs are less after three years, when all nurses are trained and full caseloads attained)

More recent estimates, provided by the national offices for some of these programs, suggest that the cost of the Parent-Child Home Program may be about $2,000 per year; and $3,000 - $5,000 for Healthy Families America.

Depending upon the services offered, home visiting programs have employed Medicaid, State Children's Health Insurance Program (SCHIP), Title V Maternal and Child health Services Block Grant, TANF, U.S. Department of Education, Head Start, California Department of Education, Even Start, Title I, local and county funding, First 5 dollars, and funding from private foundations and corporations.[1]

Fully 80% of the program costs are direct costs for personnel. The main drivers of program costs include staff qualifications/experience; home visitor caseload; number, frequency, and duration of visits; travel distance and mode of transportation; training, supervision, and administration; record-keeping and service documentation; and parent participation time.

In time studies of how home visitors spent their time across several programs, it appears that home visits account for only a small percentage of their time: perhaps 25% in a Monterey County PAT program, 10-33% in other programs. Home visitors spend most of their time on administration and paperwork. This suggests that programs should examine the ways in which they are staffed, and find ways to cut down on home visitor paperwork (perhaps using other staff to handle some of the details).

[1] For more information about funding for home visiting programs, see Thompson, L., Kropenske, V., Heinicke, C.M., Gomby, D.S., & Halfon, N. (December 2001) *Home Visiting: A Service Strategy to Deliver Proposition 10 Results*, in N. Halfon, E. Shulman, & M. Hochstein, eds. Building Community Systems for Young Children, UCLA Center for Healthier Children, Families, and Communities. Available at http://healthchild.ucla.edu. Also, Cornell, E. (June 14, 2002). The benefits and financing of home visiting programs. NGA Center for Best Practices. Issue Brief. Available at: http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF%5ED_3927,00.html

9. What Can We Do to Maintain Program Quality?

Even the best-designed home visiting program can founder if services are not implemented well. The key contributors to program quality are the following:

- family engagement,
- the delivery of the curriculum,
- the skills and abilities of home visitors to forge relationships with the families,
- cultural consonance between the program and its clientele, and
- developing appropriate responses to those high-risk families that are facing depression, substance abuse, or domestic violence.

Engagement: between 10% and 40% of families who are invited to enroll in intensive home visiting services decline. As many as 50-70% of families leave home visiting programs before services are scheduled to end. Families often receive only about half the visits they are scheduled to receive, and usually not more than two visits per month.

Curriculum: the program curriculum must address directly the goals that the program is designed to achieve, and the curriculum must be delivered with fidelity. In other words, if the program seeks to promote child development, then services must provide families with tools that will directly promote the development of their children. Further, home visitors must understand and endorse the program goals, or services are unlikely to be effective.

Home visitors: Home visiting programs rise and fall on the skills of their visitors. Some programs provide as much as 6 months of intensive pre-service training for their visitors, others provide as little as a week or two. Programs vary in their caseloads and in their levels of supervision for home visitors.

Cultural consonance: Most home visiting programs seek to influence parenting behavior, but there is probably no aspect of family life that is as culturally-bound as is parenting behavior. Research is limited on the parenting practices that are best across cultures and families of different races and ethnicities. But, there are strong suggestions that programs that do not treat different beliefs about parenting with respect and understanding will not be successful. On the other hand, toning down clear messages merely to keep families enrolled will not help programs achieve their goals.

Special families: Families may face some problems that require special attention because they have especially negative consequences for family functioning and for children. But, these are precisely the areas that most evaluations suggest that home visitors feel awkward about or ill-equipped to address: substance abuse, maternal depression, domestic violence, and contraception.

But, if programs do not deliver high quality services, families will not benefit. Therefore, program sites, program funders, and national program offices should all take steps to build high quality services.

To address these issues of implementation, individual program sites should:

1. Make sure that they adhere to program standards established by the national headquarters for their program model. If programs are not affiliated with a national model, then they should make sure that they establish standards for the key components of program quality listed above.

2. Monitor performance on program standards regularly and provide feedback to staff.

3. Seek out opportunities for cross-site comparisons and learning.

4. Try rapid improvement cycles, in which approaches to quality problems are tried for a few months, data are collected to monitor their effects, and, if successful, the new approaches are implemented. If they are not successful, then other approaches are tried.

Program funders and funding agencies should:

1. Support the costs of program monitoring and quality improvement, including data collection, MIS development, data analysis and feedback to program sites.

2. Explore the development of common definitions for key program quality components (e.g., terms such as enrollment, attrition, missed visit, reasons for exit, paraprofessional).

3. Require reporting around key program quality components, using common definitions if they have been developed, or asking programs to include their definitions if common definitions are not yet developed.

4. Support opportunities for rapid improvement cycles.

The national offices for key home visiting models should:

1. Develop performance standards for their models that address issues of engagement (including enrollment, service frequency, attrition rates, and involvement of families in complementary services such as parent group meetings); staff background, training, caseloads, and supervision levels; cultural consonance; and addressing families with special needs. Developing definitions for terms related to engagement are especially important because these terms are used very differently across models and program sites.

2. Require program sites to feed information back to the national offices on some or all of these performance standards.

3. Develop feedback mechanisms to deliver information back to program sites so that each site will be able to see how its performance compares with that of other sites that serve similar populations.

4. Offer technical assistance to sites that fall below stated performance standards. Such technical assistance could take the form of peer support, in which staff from program sites learn from one another and perhaps visit sites that excel.

5. Monitor the aspects of quality that are associated with better outcomes for children and families at as many sites as possible.

10. What Can We Expect?

The very mixed results from home visiting research suggest that programs cannot always expect to produce the same results as did the model demonstration programs upon which the program was based. To even have a chance of replicating those results, however, programs should be replicated at the same funding levels as in the original demonstration programs (because those control staffing and caseloads), and employing the same curricula and staffing patterns.

However, no matter the care involved in the replication, expectations for program success should be modest, because behavior change is hard to achieve, and home visiting is a fragile means by which to achieve it. Home visiting programs use perhaps 20-40 hours of contact to try to alter the behavior of individuals as a way of addressing large societal problems such as child abuse and neglect, lack of school readiness, and teen pregnancy, and they struggle with problems of implementation all along the way.

Families are most likely to adopt changes when the change is easy to make, clearly defined, and/or results in a clearly visible change. For example, placing children on their backs to sleep is a behavior change that is easy to explain and that is relatively easy for parents to implement. Many other changes, such as reading to an infant every day or changing vocabulary and conversation styles to elaborate upon a toddler's speech patterns, are more complicated to explain, to model, and to learn, and they require a great deal more effort on the part of parents to implement.

Home visiting programs also sometimes serve families who may not see the need to change their behavior. When mothers see all the children in their neighborhood at about the same developmental level as their own children, when they see their relatives rearing their children the same way they do, when they see their neighbors struggling with the same work, husband, boyfriend, and money issues they have, then they may not see the need or have the motivation to change.

How much more difficult, too, is change when the problems are societal or community-wide. If families live in communities where poverty is entrenched, then programs that

focus solely on individual change rather than broader policy solutions may be out-matched.

In sum, policymakers and practitioners should maintain modest expectations for home visiting services. Because home visiting programs will not and cannot serve the needs of all families, other service strategies should be offered to complement home visiting services and to help families and children who opt out of home visiting services. These may include more child-focused services (such as child care), parent-focused services that are delivered in another way (e.g., parenting classes delivered in the community or on the job site), or other policy alternatives designed to increase the connections between parents and children.